life as one reported here. The tumor metastasized entirely by the blood stream, as disclosed by autopsy. The second case shows a five-year cure by simple castration.

Glenwood Building.

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DISCUSSION

ORAN I. CUTLER, M. D. (Loma Linda).—It has been my privilege to examine sections from both of these tumors. Those taken from various parts of the original tumor, in the first case reported, are all of the same appearance. The structure is indistinguishable from that of sarcomata arising in fibrous tissue in other parts of the body. If a teratomatous area existed in the tumor, it was very tiny at the time the tumor was removed. The mode of metastasis is more in keeping with that of an ordinary sarcoma than with the usual spread of embryonal tumors of the testicle.

In the second case reported, while the main mass of the newgrowth removed was outside of the testicle, there are areas in the tumor which are alveolar in structure and in which lymphoid cells are fairly abundant. In other parts of the tumor the cell arrangement is more diffuse, and the cells are mostly spindle-shaped, but less definitely fibroblastic in nature than those in the first case. This growth is apparently an embryonal tumor, in which there is a variation in structure such as is seen in different portions of many malignant tumors.

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E. FORREST BOYD, M. D. (909 Roosevelt Building, Los Angeles).—The two cases reported by Doctors Card and Bingham are individually interesting, the one from advanced age, the other in the fortunate outcome, and they are almost classical examples of statements made in literature concerning the distribution of the disease, on the one hand, and the efficacy of comparatively early surgery on the other.

The authors allude to the relative and absolute rarity of such cases, and the controversial elements of the classification. Despite the universal scarcity of neoplastic diseases of the testis, there has been and is a growing amount of animated interest in the subject, with its consequent reflection on the current medical literature. Even a hasty perusal of this literature impresses one with the convergence of discussion on three points: origin, nature, and pathology of the tumors.

As a result of generations of discussion among pathologists relative to the nature and origin of testicular tumors, much of the fog-banks of controversy have been dissipated and we are at present confronted with two rather conclusive theories of classification. One large group consists of teratomata, a smaller group of the seminoma type, and a disputed third group, consisting of the sarcomata, constitutes 1 to 2 per cent. The fact remains that the histopathology of tumors of the testis is in many cases conflicting, and often even misleading, which makes an accurate or definite classification very difficult.

We are face to face with the impressive fact that malignant neoplasm of the testis is a serious, though rare, condition, and that the patient as a rule does not see his physician until after metastasis has taken place.

The success of treatment, as in so many surgical and medical cases, depends upon the sensitive and often faulty strand of the medical fabric known as diagnosis. However, many cases are promptly diagnosed in an accurate manner, but the presentation of the patient for examination has been too long delayed. At the present time radical and early surgery, combined with radiation as determined by the more recent concepts of that portion of the surgeon's armamentarium, should be the treatment of choice.

THE PROBLEM OF DEMENTIA PRAECOX

By DONALD A. MACFARLANE, M. D.
Berkeley

DISCUSSION *by William Palmer Lucas, M. D., San Francisco; A. L. Gleason, M. D., Oakland; Edward W. Twitchell, M. D., San Francisco.*

IT is not too much to say that of all the problems concerned with mental health and disease, one of the most puzzling, elusive and discouraging is the one comprised in that large and varied group which we conventionally refer to under the heading of "dementia praecox." It is puzzling to the physician to attempt to gain some understanding of the underlying forces and conditions involved, or for the practitioner whose duty it may be to bring some measure of understanding and peace of mind to the families or friends of his schizophrenic patients. It should be the concern of all those whose job it is to deal with the problems of childhood and adolescence—teachers, social workers, parents, and doctors. It is discouraging for the therapist who attempts the arduous task of dragging these patients back from the brink of mental disaster; and, if he be honest, he will often question whether, after all, his ministrations have had a great deal to do with such "recoveries" as may accrue to his credit. It is elusive for all those whose vital interest in childhood urge them on in the search for the early signs of distress, the

warnings and the danger signals, by which they may know that an individual is beginning to lose his battle for adjustment with a rigorous environment and is showing the first cracks in the structure of his personality—cracks which will lead, eventually, to a dilapidation and disintegration of his habits and personality. It is a problem requiring the utmost of clinical acumen and human understanding, unless we are going to remain, as so many of us now are, content to pin on a diagnostic label and dispatch the patient to oblivion in some custodial institution.

QUESTIONS WHICH ARISE

The following paragraphs are an attempt to compress into succinct form a discussion of a few of the questions that any physician may have put to him in his professional capacity, or which may have arisen in his own mind when he has been confronted with these trying problems.

The questions that most frequently come up are: (1) Just what *is* dementia praecox? (2) Is the outcome really hopeless? (3) What are the indications by which one might have known ahead of time that something was going wrong? (4) "Now that this has happened to John, is it safe for his brothers or sisters to marry?"

SOME SALIENT FEATURES IN SCHIZOPHRENIC PICTURE

It will suffice, in refreshing our minds concerning the general outlines of the schizophrenic picture, merely to recall a few of the salient manifestations of this process of progressive psychobiological disorganization: the simple type, with its gradually developing apathy, loss of interest and let-down in efficiency and activity; the hebephrenic type with silly behavior, grimacing, odd mannerisms, stereotyped activity, untidiness, queer utterances; the catatonic type with stiff and awkward motions, catalepsy or the tendency to hold fixed postures, negativism, tantrum reactions, mutism, and stupors; and the paranoid type with suspiciousness, ideas of self-reference and delusions of persecution. We are familiar with the general tendency among these patients to present hallucinations in all sense modes and queer delusions of all kinds. On the somatic and physiological levels we see the mild gastro-intestinal malfunctions, the many signs of autonomic instability, the confusing and fluctuating disturbances of reflexes—in short, a diffuse and complex set of mental and behavior symptoms that are queer, odd, bizarre, and incongruous.

It was much more than mere academic hair-splitting that led Adolf Meyer, as far back as 1903, to revolt from the classical descriptive and disease-entity concepts of the functional psychoses in general, and dementia praecox in particular, that psychiatry had inherited from the brilliant pioneer work of Kraepelin. It was essentially an urge to envisage the human organism in all its complexity and all its manifestations of adaptation. It made him dissatisfied with the empty neatness of such etiologic factors as "auto-intoxication," and question the validity of the findings of those who sought the critical answers under the microscope. It led him to say, "Instead of merely appealing to cortex changes of obscure correlation, or to equally obscure auto-intoxications, or to arrest of development, I refer to the disharmony of habits, disharmony of those regulations which shape a well-balanced economy: the intestinal and circulatory functions, the sexual life and, above all, the trend of interests depending in its integrity and efficiency on a certain equilibrium. . . . And it will be our duty to define in actual cases what sets of habits we find interwoven, and with what effect. This directs the attention to the investigation of matters which are open to influence in education, and to a more rational management of dementia praecox, as well as many other mental disorders: and habit disorder is to be treated by habit training, not by vague encouragement and excessive protection and mere fighting of incidental disorders." [1] And there is little doubt that this point of view has furnished the impetus toward the modification of our concepts and ways of thinking about schizophrenia, to the end that we are coming more and more to use, for their dynamic connotations, such terms as "schizophrenic processes or reactions" rather than to say that "the patient *has* schizophrenia" or "he *is suffering from* dementia praecox." And these schizophrenic processes mean what the term implies—an odd sort of "splitting off" of fantasy and subjective ruminations from considerations of the concrete world of reality with all its problems and demands for adjustment. These demands and problems are implicit in the very process of growing up: demands of habit training, of adjustment to a social milieu, demands of school and work and family formation, the necessity to manage and adjust to instinctual drives, and so on. While it is eminently proper that these patients should continue to be studied from the point of view of biochemistry, pharmacology, histology and endocrinology, yet, as the data in these fields accumulate, it becomes increasingly evident that a true conceptualization of these processes is to be couched in terms of *inadequate life adaptation and personality and habit disorganization, in a setting* of more or less subtle and obscure biological "disharmonies."

Kraepelin insisted that if a dementia praecox patient recovered, it meant that the diagnosis had been incorrect. Dementia praecox was, by definition, a disease from which one did not recover. But with the change from this older disease-entity concept, based implicitly on prognosis to one that views a basically fragile and inadequate organism making unfortunate adaptations to the job of getting on in the world, we are ready to modify our former unduly pessimistic attitude toward prognosis. There is no doubt that we often see schizophrenic "flurries," passing reactions having the indubitable characteristics of the early dementia praecox picture. It is equally true that we witness individuals, pretty obviously headed for a mental break-up of this sort, shunted back onto the road to mental health. And we have the example, un-

[1] Studies in Psychiatry. Nervous and Mental Disease Monograph Series, No. 9, Vol. 1.

usual, to be sure, of the institutional patient who miraculously "recovers," for no known reason, after years of complete dilapidation. In spite of these encouraging facts, however, it still remains true that the outlook for these people is definitely grave.

It is the frequent and distressing preoccupation of a schizophrenic patient's relatives that everyone, especially themselves, failed to recognize the signs of the approaching storm until it was upon them, and it is probably at this point more than any other that the responsibility of the physician or the teacher lies. While prescience is often impossible, equally often one finds that the storm signals have been flying for months or years. By dint of vigorous propaganda, largely at the hands of the mental hygiene enthusiasts, most of us have acquired the formula supposed to describe the preschizophrenic personality—shy, seclusive, sensitive, shut-in—and there has grown up a perfect furore for socialization and extraversion of such youngsters as seem to fall in these catagories, with a failure to discriminate between the qualitative differences that make "introversion" for one child a possible asset, and for another a liability. The recent study of Kasanin and Rosen [2] should shock us out of our uncritical confidence in the alliterative "shy, seclusive, shut-in." Beyond a doubt such personality traits often figure in the prepsychotic picture, but these workers found them as antecedent traits in only about 16 per cent of their group of 151 schizophrenic patients.

IMPORTANT FACTS FOR THE PHYSICIAN

What, then, are some of the indications to which the mind of the physician should be sensitized? There *is* a sort of shy, seclusive shut-inness which carries to the intuitive clinician a feeling of avoidance of the rigors of brass-tack living, the shrinking of an inadequate personality from the manifold stresses of life. A youngster showing these trends is apt not to form valid and productive substitutes in the form of well-organized and individualistic endeavors, but rather he tends to wander off into the poppy-fields of fantasy; and a certain "goodness" that he may show is more often born of inner timidity than of strength and hardiness.

With the onset of puberty and the progress of adolescence there is frequently observed a growing tendency to withdraw from the more usual and normal interests, and the substitution of preoccupations with abstractions—religion, morals, ethics, or empty and immature interests in philosophy. One would feel a bit more comfortable if he could assure himself that an adolescent who begins writing poetry or develops an urgent but immature interest in, say, Karl Marx, showed no obvious indications of those subtle, premonitory deviations that suggest a precarious situation. A common picture is seen in somatic concerns and anxieties, often bizarre and distorted, with a general and progressive let-down in energy output without apparent physical cause. (This is not to be confused with a "Tom Sawyer" sort of thing, pumped up for the purpose of attention-getting, a picture that is usually transparent and transitory and not accompanied by any essential or continued decrease in activity.) The hypochondria may focus on the heart or other viscera; and there are the very common "headaches" which turn out, upon questioning, not to be the usual familiar headache, but head "sensations" of pressure, constriction, emptiness or "queerness." These anxieties may become so obsessive as to amount almost to phobias; as in the child who at the age of nine develops a fear of going blind and at fifteen begins to show the unmistakable signs of disorganization. These conditions are not "just neurasthenia," and in any child or adolescent complaints suggesting this term should be looked upon as of possible serious significance. Concern, conflict and preoccupation over sexual matters are so frequent a background for these processes, especially in those social strata where conventional taboos have become firmly entrenched, that it is small wonder that a gruesome folk-lore has grown up around the subject of masturbation; and in this connection there may appear a hypersensitiveness, especially toward friends and playmates, with the feeling that "they act kind of different toward me" or "they don't like me as well as they used to."

Again, we may see the unaccountable tantrums punctuating, perhaps, an extended period in which the emotional life seems to be undergoing atrophy or distortion. School work slumps, and there are complaints of difficulty in "thinking" and "concentration." Religious or occultistic interests may appear, with a tendency to moralize with other members of the family for their care-free interests in a good time; or prudishness and an oversensitive aversion to the opposite sex, often in a setting of irritable negativism and unexplainable whim.

The psychasthenic picture, marked by tenseness, obsessive ruminations and compulsive or ritualistic behavior, or a precocious overconscientiousness in which there is placed a solemn, anxious or distorted emphasis on real or imagined responsibilities, or the appearance of hysterical or conversion phenomena—these trends, especially in the younger person, imperatively demand more attention than the mere advice to "snap out of it."

We should hasten to say that any of these premonitory trends may exist in a person in no obvious danger of serious mental illness; but when they are found it is inexcusable for the physician not to keep in mind that the welfare of the patient who shows them demands careful and understanding attention. This is especially true where there is a lack of a certain "balance" in the form of vigorous and more or less consecutive and organized interests in work or play, and which, on the whole, should be reasonably "extraverted."

HEREDITY AND MARRIAGE

Just as the causes and contexts of the many varieties of schizophrenic processes are clouded

2 Kasanin and Rosen: Clinical Variables in Schizoid Personalities, Archives of Neurology and Psychiatry, 30:538 (Sept.), 1933.

and confused by seeming correlations, and the prognosis grave and discouraging, so also is another dilemma raised when the question of heredity and marriage comes up. And again we are unable to give categorical answers, for the data on the hereditary aspects of mental disease are inconclusive. When we have attempted to balance one research study against another contradictory one, and to combine these resultant conclusions with impressions from our own clinical data, we seem to be left only with an impression of trends and tendencies. We come to expect more frequent manifestations of basic instabilities among siblings of schizophrenics than among preceding or successive connections. Yet the world is full of brothers and sisters of dementia praecox patients who have been normal, stable people, and who have begot apparently normal children. The betting odds, if we may express the probabilities in such terms, would probably favor the prediction that siblings of schizophrenics, taken as a group, will produce descendants among whom will be found more cases of deviations than would be found among descendants of siblings taken at random. The best answer to each individual question lies with each individual case. In taking our routine family histories, we often slur over data and neglect pointed scrutiny that would disclose among siblings of patients, trends that would lead us, in one person, to hazard a favorable prediction and, in another, a more questionable one. We are all aware of the need to examine other members of a family when one is found with a positive Wassermann, and, similarly, in cases of these "functional" mental disorders, where the question of marriage is so apt to arise, a study of the individual will be our best, though by no means infallible, guide for judging what may be expected to happen to him.

COMMENT

The fruitful time to do something about this whole problem, as in so many other problems of medicine, is during the stages when one may expect to forestall a complete pathological picture. There is, after all, excellent reason for the usual feeling that the schizophrenic process, once it has got well under way, is one that is extremely difficult to ameliorate; otherwise it would not be true that this group constitutes a higher percentage of the patients in our mental hospitals than all the others put together, and that a smaller percentage of them is returned to society in a condition even approximating normality. The big problem is one of prophylaxis, requiring insight on the part of the physician, and a vigorous and intelligent coöperation on the part of all those having to do with the welfare and training of youth. It requires of the responsible members of the community a well-balanced awareness that such problems exist—well-balanced, so that one does not become apprehensive about a bogey if it does not exist, but at the same time keeps a vigilant eye out for situations that genuinely need attention.

2664 Shasta Road.

DISCUSSION

WILLIAM PALMER LUCAS, M. D. (490 Post Street, San Francisco).—Doctor Macfarlane's article, "The Problem of Dementia Praecox," is much needed and gives the story of the various types of dementia praecox very well. It is heartening to see that the modern psychiatrist is not so pessimistic in regard to the outcome of dementia praecox, provided it is recognized early and treated sympathetically and continuously. What he says in regard to the fact "that these premonitory trends may exist in a person in no obvious danger of serious mental illness; but when they are found it is inexcusable for the physician not to keep in mind that the welfare of the patient who shows them demands careful and understanding attention," should be emphasized over and over again to every practitioner. Only by the early recognition of these unstable personalities and lack of balance, and by careful observation and supervision, can anyone determine in the early stages whether these symptoms are leading toward real dementia praecox, or whether it is just one of those passing phases which a good many adolescents go through. What Doctor Macfarlane says in regard to heredity and marriage is also well worth observing, and, as he observes, "the best answer to each individual question lies with each individual case." Again, he reëmphasizes the whole situation in declaring that "the fruitful time to do something about this whole problem, as in so many other problems of medicine, is during the stages when one may expect to forestall a complete pathological picture." The article is well worth reading and taking to heart.

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A. L. GLEASON, M. D. (400 Twenty-ninth Street, Oakland).—It is well known that the majority of the schizophrenic patients in institutions showed early manifestations or symptoms of this disorder so clearly described by Doctor Macfarlane. These patients were described in terms of personality maladjustment, and were easily recognized by teachers, physicians, and administrators.

Instead, however, of these children receiving help from their school environment, at that time they found themselves out of step, different, frequently disciplined and usually ostracized by others of their age and class. As a result, they only withdrew further from reality.

In the modern education, intelligence training is considered only one aspect of the educational aim. It also involves aid and training in learning how to meet one's problems, and provides for the wholesome, well-rounded growth and development of the entire personality.

The modern progressive schools, child-guidance clinics, Parent-Teacher associations, and various other organizations are overcoming the old one-sided conception of education. Parents and teachers are becoming familiarized with the early symptoms of schizophrenic patients. Child-guidance clinics have been established, and therapeutic training is being furnished. Hence, I believe that within the next generation we should see some very encouraging results.

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EDWARD W. TWITCHELL, M. D. (909 Hyde Street, San Francisco).—Much water has run under the bridges since the days of Kraft-Ebing, when most of the patients whom we would nowadays classify under the heading of schizophrenia were regarded as varieties of paranoia. During those years an enormous change has taken place in our conception of these conditions, and a great number of individuals are now grouped as having a schizophrenic reaction, or having schizoid mentalities, who then would hardly have been regarded as patients for the psychiatrist.

The schizoid type of reaction is found in many an individual who must be regarded as perfectly normal. This is notably so of such writers as Gertrude Stein and her imitators, or of such artists as Picasso. These individuals have a mental process which is inconceivable to the ordinary man.

I am convinced that when Gertrude Stein writes such a thing as "Three Sitting Here," or the libretto of her recent opera, she writes it just as spontaneously as James Norman Hall writes his sea stories. She is, in other words, a facultative schizophrenic, and anyone not schizoid in type who attempted to do the same thing would fail completely; just as an ordinary draftsman would be completely at a loss to do the things which the ultra-modern seem to do so naturally. To the psychiatrist there is nothing strange in the productions of a Gertrude Stein or a Picasso—they are doing something that resembles very strikingly the speech, writing and drawing of his schizophrenic patients, and he feels himself on familiar ground.

We have, therefore, a large number of individuals, living successful lives, well adjusted to their surroundings, who none the less have an entirely different psychic make-up from that of the ordinary man. It is only when they become unable to shift themselves at will back onto the ordinary paths that we have to regard them as pathologic and candidates for psychiatry.

So the psychiatrist of the present day finds his field enormously widened as compared with that of forty years ago, and one of his most faithful sources of effort is going to be in dealing with those whom he has learned to recognize as having this type of mental process long before it can become evident to the untrained observer.

It is reasonable to believe that, seeing these things in advance, he may be able to protect such individuals if given opportunity, and to prevent their coming to that point where their difficulties "jump to the eyes." This is mental hygiene at its best.

"Auto-intoxication" has been worked to death in all fields, let alone psychiatry, and hardly a psychiatrist now thinks of schizophrenia as the result of autointoxication, nor does any new book appear with dementia praecox grouped with the "endogene Verbloedungsprozessen." We look for more subtle things, and modern neurophysiology has shown us that there must be paths of which we know little which can be used on occasion when the necessity arises: schizophrenia may be simply the habitual use of unconventional paths, and it may be well to say of the patient, not that he has dementia praecox, but that he has contracted a schizophrenic habit.

One has learned that "dementia praecox" no longer closes the door of hope to the individual, and the more extensive one's experience, the more can one recall of those who, apparently hopeless and deteriorated, have made remarkably complete and lasting recoveries; and the more one sees of the extraordinary changes which take place, the more does one become convinced that sooner or later a key or a bunch of keys is going to be found to unlock the doors to this problem.

When one sees a catatonic, rigid, stereotyped, mute and negativistic, and one who has been so for weeks or months, return within a few weeks' time to a condition of apparent normality and remain so for months and years, the more hopeful does one become that it is only a matter of time before we shall be able to do something which will enable us to bring about such transformations at will, and not grope more or less blindly as we do at present. Our inability to do this now also means that we are unable, except in a very uncertain way, to head off what we feel pretty sure is coming; so that our prophylactic treatment is almost as futile oftentimes as is our curative.

We still know little about heredity in the insane, and statistics are fallacious; but the longer one goes on, the less does one feel justified in frightening or worrying a family in which a case of schizophrenia has appeared.

On the best tree in the orchard one finds deformed and imperfect fruit. So the best family stock may occasionally produce an example of schizophrenia. One should not condemn the rest of the fruit or hesitate to graft or bud from that stock.

Doctor Macfarlane has made a worthy contribution to what is probably the most important psychiatric problem of the present day.

COMPULSORY HEALTH INSURANCE*

By FREDERICK L. HOFFMAN, LL.D.
Philadelphia, Pennsylvania

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THE practical interest of the British medical profession in the administration of national health insurance is perhaps best illustrated by the following precise statement in a recently published volume on "The British System of Social Insurance" by Percy Cohen, a recognized authority on the subject:

"Nearly 16,000 doctors are on the panels; over 10,000 chemists' shops supply medicines and appliances to insured persons; every year the medical profession gives 60,000,000 attendances to insured persons and 58,000,000 insurance prescriptions are dispensed. Every day the insurance medical service attends to some 140,000 patients."

The relative importance of this statement may be better understood when it is pointed out that since 1881 the ratio of doctors to population in the British population has increased from 1 in 1514 in the year 1881 to 1 in 1337 in the year 1901, and from 1 in 1038 in the year 1921 to finally 1 in 881 in the year 1931. Thus, the number of patients to a doctor is constantly diminishing, increasing the economic problem of the medical profession. The 16,000 doctors who are on the panels are, for all practical purposes, state employees and subject to a wide range of rules and regulations that have nothing to do with the efficiency of medical practice, but are concerned wholly with the economics of the administration.

CAPITATION FEES

The capitation fee in 1931 was nine shillings per patient, but this was arbitrarily reduced by the government, on grounds of national economy, to the extent of 10 per cent. Since the National Health Insurance Act of 1911, there have been seven alterations of the capitation fee, the first four being increases. The fifth was a reduction accepted by the insurance practitioners in view of the economic conditions of the time. The sixth arose out of a Court of Inquiry, which awarded a higher sum than that offered by the Ministry of Health, the latter amount having been refused by insurance practitioners on the advice of the Association. The seventh alteration, which is the present temporary reduction of 10 per cent, came into force in October, 1931. A correspondent, writing in the *British Medical Journal* of January 14, 1933, complained bitterly of the Association's inability to protect the interests of the practitioners. In response, it was pointed out that "perhaps he was ignorant of the four increases obtained through the efforts of the Association, which forced the Government in 1912 to increase the capitation fee from 4s. to 7s. 3d. As a result of this action insurance practitioners as a whole received, up till the end of 1931, an extra 60,000,000 pounds. In 1918, and again in 1919, the Association obtained for certain sections of insurance practitioners bonuses which, from 1918 to the end of 1931, brought about a further increase of 1,500,000 pounds. When the Association,

* One of a series of articles on compulsory health insurance, written for CALIFORNIA AND WESTERN MEDICINE by the well-known consulting statistician, Frederick L. Hoffman, LL. D. Articles in this series were printed in previous issues as follows: I, in April, page 245; II, in May, page 361; III, in June, page 411; IV, in July, page 33.